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Audit of hospital transfers January to March 2006 from Sussex police custody

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ABSTRACT

The aim of this audit was to determine a baseline for timing, numbers and case mix of detainees referred to hospital for medical assessment in order to review the effectiveness of existing custody procedures for the management of medical emergencies.

Data was examined for the 3-month period January to March 2006. A total of 12015 detainees were processed during this period, 188 patients identified as requiring hospital assessment, a hospital transfer rate of 1.57% for the period, 80 cases (0.65%) were for potentially life threatening conditions. The health care team assessed 37.7% of all detainees and were recorded as involved in 151 of the 188 cases transferred (80%).

The categories of patients sent to hospital included head injury (26/188 or 13.8%), overdose and poisoning (20/188 or 10.6%); chest pain (17/188 or 9.0%), collapse (12/188 or 6.4%), unrousable intoxicated (10/188 or 5.3%), possible drug swallowers (7/188 or 3.72%), breathing problems (4 or 2.12%), acute confusional state (3/188 or 1.6%), 2/188 had a query deep vein thrombosis, one diabetic problem and one acute allergic reaction. The largest category of all was for a miscellany of minor injury unit care.

1. Introduction

The timely transfer of a detainee from a police custody centre to hospital for assessment and treatment of an acute medical disorder can be crucial to the prevention of a death in custody. Prevention strategies in place, such as the walky-talky rule,[1] Custody Risk Assessment Questionnaire, custody staff training, the availability of a medical assessment, and an effective information exchange with the hospitals, aim to minimise the risk.

By auditing a series of all detainees referred to hospital from the police custody centres in Sussex we had an opportunity to determine a baseline for numbers and case mix of detainees referred to hospital for medical assessment; to review the effectiveness of existing safeguards; to assess the role of the custody team including the medical service in identifying, treating and referring such emergencies; also to identify training needs for both recognition and appropriate response in relation to medical conditions for all staff involved.

The study analysed detainee transfers, for the 3-month period January to March 2006, from the six police custody centres in Sussex to the seven receiving general hospitals (to the emergency department or directly to a medical or surgical team). The custody centres have Custody Sergeants and civilian custody assistants and supervisors on site, with a mobile team of healthcare staff comprising three Forensic Nurses and one Forensic Medical Examiner (FME) on duty countywide and a manager on call. (The staff also cover the non-custody workload, Road Traffic Act cases, etc. in A&E and the victim suite cases). The healthcare staff assess some 1800 detainees per calendar month, which is approximately one in every 2.65 detainees.

2. Methods

(1) Case records were identified using the computerised custody record system (CEDAR) and Business Objects to search for cases referred to hospital within the study period.
(2) Custody records were thoroughly examined retrospectively in order to identify the timing of referrals, the staff involved, the reason why referral to hospital was made, the timings at which detainees were first identified to require hospital assessment/treatment and how quickly transfer to hospital was established.
(3) For confidentiality, once records were identified, the data was entered anonymously using custody reference numbers.

3. Results

A total of 193 records were reviewed. One was excluded as incomplete and there were four duplicate records, making a total

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[1] The Sussex walky-talky rule is that an ambulance should be called to take a person to hospital if they cannot walk or speak in whole words with some meaning.

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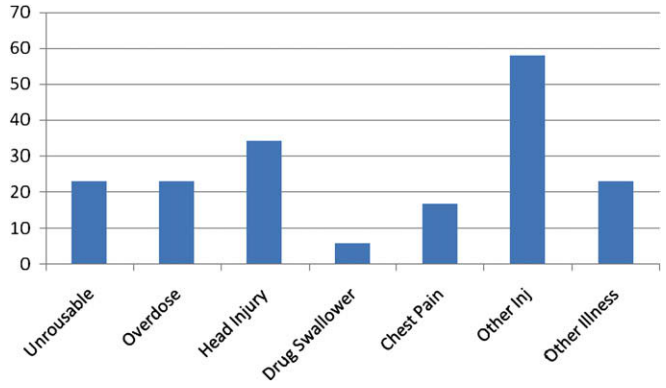

Chart 1. Broad types of medical groups of cases.

of 188 records of transfer for the time period, so just over 62 cases per calendar month.

A total of 12015 detainees were processed during this period giving a hospital transfer rate of 1.57%.

The categories of patients sent to hospital included head injury (34/188 or 18.1%), overdose and poisoning (23/188 or 12.23%); chest pain (17/188 or 9.0%), unrousable (23/188 or 12.23%), ?drug swallowers (6/188 or 3.19%), breathing problems (4 or 2.12%, acute confusional state (3/188 or 1.6%), two had a query deep vein thrombosis, one diabetic problem and one acute allergic reaction. The largest category of all was for a miscellany of minor injury unit care, possible fractures, stitches needed, and so forth (see Chart 1).

The cases were divided into time blocks. This shows that for a range of disorders the decision to transfer is not made until later during the detention. In some this reflected a clinical change, for example chest pain or collapse, or alternatively a deliberate delay, for example with paracetamol overdose an arrangement being made to transfer at the 4 h optimal point after ingestion for blood levels, or stitching needed but only when sufficiently sober and cooperative. Custody medical assessment, with treatment and delay until release from custody also occurs where clinically appropriate.

Nine MHA 136 detainees were transferred within the first hour, two had been removed from cars with exhaust pipes connected into a car raising the possibility of carbon monoxide poisoning, one of the two had also admitted to a drug overdose, three other overdoses, one alcohol related hallucinations (? Delirium Tremens), one chest pains, one severe drunkenness in a young person and one to remove a tight finger ring (see Chart 2).

151 of the 188 (80%) cases sent to hospital followed healthcare staff involvement.

The responsible person in part reflects who was present. At booking in a Sergeant will recognise some conditions needing urgent transfer, telephone advice may be sought to confirm the decision, this is not always recorded, an immediate 'Fit to Detain' assessment may be requested to a Forensic Nurse or FME already present, who may then arrange the transfer. Alternatively an urgent or non-urgent call-out may be requested. The nurses are required to routinely discuss with the FME decisions to transfer (see Chart 3).

The cases were classified as 'emergency' and high risk if there was a potential life threat, and 'urgent' but low risk where hospital assessment was needed but was not life threatening.

The arrest category did not appear to be significant except for Drunk and Incapable, three out of the four referrals were for potentially life threatening indications and 6.3% of Mental Health Act 136 patients had a need to attend hospital, with 3.8% having a potentially life threatening problem (see Chart 4).

	A&E <1Hr	A&E 1-2Hr	A&E 2-4Hr	A&E 4Hrs+	All
Unrousable	12	4	1	6	23
Overdose	11	10	1	1	23
Head Injury	13	8	9	4	34
Drug Swallower	2	2	1	1	6
Chest Pain	6	3	3	5	17
Other Inj	24	13	6	15	58
Other Illness	7	4	7	6	24
Not Known	0	0	1	2	3
Total	75	44	29	40	188

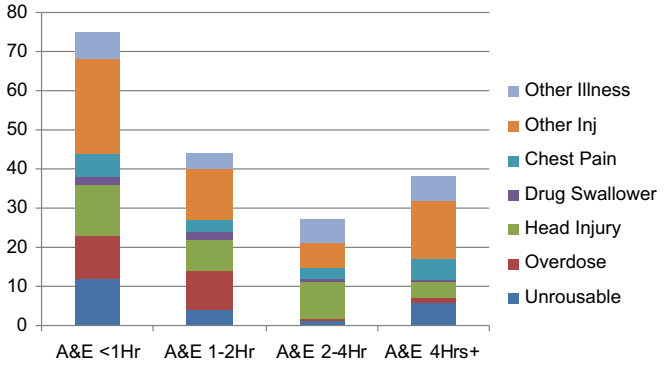

Chart 2. Time interval before transfer related to type of case.

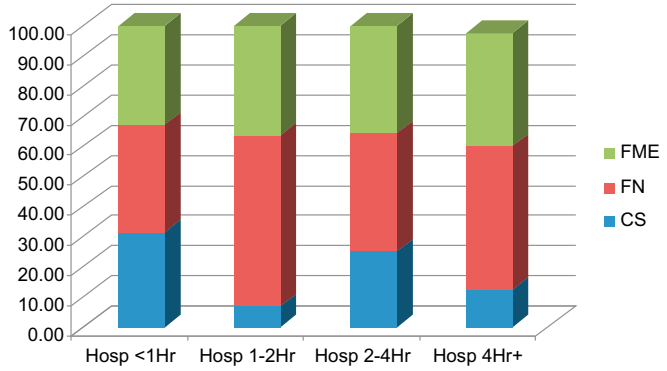

Chart 3. Custody Sergeant, Forensic Nurse or Forensic Medical Examiner arranged transfer.

4. Discussion

This audit helps to define the type and number of high-risk patients who develop the need to go to hospital for emergency assessment whilst in police custody. It also sets a benchmark for the numbers transferred to hospital by the healthcare service in Sussex.

Sussex Police arrest approximately 55,000 detainees per year, and the forensic medical service sees about 20,000 of these detainees, averaging 1666 per month. Just over 62 cases are sent out to hospital each month once they have been detained in custody of which 56% have a potentially serious or life threatening problem (80 medical cases plus 26 head injured patients out of the 188 for the 3-month period).

Head injuries, overdose and poisoning, unconscious patients, collapsing patients, chest pains, breathing problems are the core components of emergencies arising in police custody. They can and do arise at variable time intervals after detention. All custody staff in Sussex are trained in resuscitation and first aid. They also

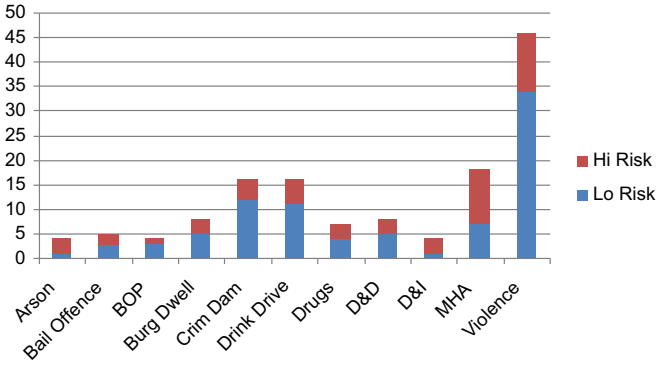

Chart 4. Relating high or low risk case to arrest category.

receive training from the Principal FMEs about medical risks, care in custody and avoiding deaths in custody. Transfers are as agreed in joint protocols with the hospital staff and based on the NICE guidelines for the head injuries, overdoses, etc. drug swallowers are dealt with according to a protocol following the Guys Hospital toxicology unit advice sheet.

The custody staff training is backed up by hard copies and computer access to a document 'Advice to custody staff' written by the Principal FMEs with the police team in charge of custody care. This gives clear agreed guidelines to follow.

The research for this document was comprehensive and included analysis of the PCA/IPCC annual reports, special reports and Home Office publications on the topics of death in custody and custody officer training.

The Custody Sergeant booking in procedure requires the cooperation of the detainee to be completed. A risk arises where the Sergeant is deliberately misled or drunkenness prevents completion despite the person being able to pass the 'walky-talky rule' of speaking some words with meaning and being able to walk. It is essential that the Risk Assessment Questionnaire is completed as soon as it is possible and that the custody staff monitor carefully with frequent rousing checks in the interim. It is notable that despite passing the' walky-talky rule' 16 cases were admitted to custody that required emergency transfer to hospital within 2 h due to altered consciousness. This figure appears to reflect the effectiveness of the civilian custody staff checks, with decreasing level of consciousness reported to the Custody Sergeant so that potentially lifesaving action was taken.

It was apparent that potential carbon monoxide poisoning detainees following arson incidents or car exhaust inhalation suicide bids, were wrongly brought to custody following advice to Arresting Officers from ambulance crew. The fact that they were then transferred indicates awareness of the medical implications by the staff reflecting training. Catalytic converters reduce the risks from exhaust fumes but cars can be adapted to increase carbon monoxide output, also idling from a cold start or prolonged inhalation can give lethal doses.[1]

This study shows that a significant number of MHA 136 detainees are brought to custody by detaining officers with conditions other than mental illness. This indicates the need for a prompt 'Fitness to Detain' assessment for such cases to exclude medical causes for the apparently disordered thinking or to assess for overdose or poisoning risk. Visual hallucinations in one case in this audit highlighting the risk of an alcoholic presenting with psychiatric symptoms when a life threatening medical complication of alcoholism is present.

One problem that was apparent, although not highlighted in the data of this study, was the issue of information transfer between custody and the hospital. The paper custody record information, and if health care staff were involved, a medical referral letter, were sent with the patient. On return to custody 'Fitness to Detain and Interview' were not guaranteed and information could be needed from the hospital to establish ongoing risk. For patient confidentiality reasons, this was not necessarily released to the attending officers, or even to the Forensic Nurses making telephone enquiries. A patient transfer form with referring information, a patient signed consent section and space for return relevant medical information was designed, agreed with the hospitals and is now in regular use improving communication.

It is now also clearly understood by the hospitals medical staff that the routine care and observations of detainees in custody is by civilian custody staff, the Forensic Nurse and FME role being primarily assessment and advice. Patients should not be sent back to custody until fit for police and civilian staff routine cell checks type care.

This audit does not pick up the review of provisional decisions by Custody Sergeants to transfer, where a Forensic Nurse or FME assessment gives a fuller picture and transfer is no longer needed e.g. treatable angina or panic attack. This is of value to the police force as it reduces the loss of active beat officers when acting as guards during hospital assessments.

A forcewide log is now kept of all critical incidents in custody, this includes all hospital transfers and is reviewed by the Custody Inspectors, manager of the civilian custody staff and medical staff at 2-monthly custody safety meetings. This allows regular discussion and feedback to all staff on learning points in relation to medical emergencies.

This audit did not attempt to assess retrospectively the effectiveness of the decision making by custody staff, nurses or FMEs, although this aspect was a possible factor affecting the data. In Sussex with, the high level of input to training about the risks inherent to the police detainees, the development of the transfer document and critical incident reviews of all transfers, the monitoring of the effectiveness of decision-making the hospital outcomes for the patients is now under constant review.

This audit has been informative, and sets a baseline for future audits.

Conflict of Interest

None declared.

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None.

Ethical approval

None declared.

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Reference

1. Routley VH, Ozanne-Smith J. The impact of catalytic converters on motor vehicle exhaust gas suicides. *MJA* 1998;**168**:65–7.